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For non-profit facilities, the capital allowance is determined by applying the capitalization rate for the mortgage component to the valuation of the facility determined by the Standard Appraised Value methodology.

As facility valuations under the SAV methodology are updated annually over a period of several months, all derived facility valuations will be standardized to July 1 of each year using the Consumer Price Index.

4. Nursing Service and Restorative Service

Nursing and related service costs, including restorative services, will be determined on a facility-by-facility basis by applying the allowable cost formula and case mix adjustments. Nursing service reimbursement will consist of an adjusted base component and allowable case mix add-on.

The base nursing services component will reflect minimum staffing patterns for nursing personnel, plus a factor to account for restorative services, and amounts reflecting Director of Nursing costs and the costs of supplies and services. Basic nursing staffing is established at a case mix score of 2.5, which reflects nursing and restorative staffing hours per patient day as follows:

# of Beds	Position	Nursing	Restorative	Total
1-90	R.N.	.20	0	.20
	L.P.N.	.50	.35	.85
	Aides	1.80	.05	1.85
TOTAL		2.50	.40	2.90
91+	R.N.	.20	0	.20
	L.P.N.	.50	.30	.80
	Aides	1.80	.05	1.85
TOTAL		2.50	.35	2.85

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Multiplying these PPD staffing patterns by the 70th percentile value of hourly wages, based on total compensation for the peer group yields the nursing services CAP, or ceiling, for each facility in the peer group.
A factor is added for supplies equal to the PPD supply costs at the 70th percentile for the bed groups determined from the submitted cost reports. An additional factor is added for the Director of Nursing (DON) by dividing the DON salary at the 70th percentile from the bed range, as derived from the submitted cost reports, by each facility's beds at 100% occupancy. Adding these factors together yields the base constant through the six-month reimbursement period.

The peer group CAP is then adjusted to a facility specific CAP based on that facility's average MDS score from the six month reporting period. The average MDS is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted nursing CAP for each facility. The adjusted nursing CAP cannot exceed 112% (MDS average of 2.8), or be less than 80% (MDS average of 2.0), of the base constant.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the reimbursement period when the case mix score derived from the MDS+, as determined at the time of monthly billing, indicates a higher level of need and care delivered in a given facility. A base case mix score of 2.9 is established as a threshold. For facilities with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, then an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then multiplied by the Nursing Rate to derive a PPD nursing services add-on.

5. Minimum Occupancy Standard

Cost adjustments will be made by applying a minimum occupancy standard of 90% of all cost centers. Actual facility occupancy is used to determine allowable cost per patient day if equal to or greater than 90%. When the actual occupancy level is less than 90%, the actual allowable per patient day cost will be adjusted to assume a 90% occupancy level.

B. Management Incentives

Management incentives will be allowed where the standard service area allowable costs are less than the total of the cost ceilings. Facilities with good management practices, and who continue to provide quality services at less than the cost ceiling, may be allowed an opportunity to share in the cost savings.

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than the cost ceiling, may be allowed an opportunity to share in the cost savings.

1. Efficiency Allowance

Fifty percent (50%) of the difference between the allowable cost and the cost ceiling will be applied to the prospective rate for the standard service area. The total of the calculated efficiency incentives may not exceed $2.00 per patient day.

2. Quality Assurance

A facility qualifying for management incentives should not have any standard-level deficiencies as defined by the surveying agency during the reporting period. Survey agency and licensure agency reports are reviewed to determine compliance with licensure, certification, and agency standards. If it has been determined that a facility has significant deficiencies in these areas, the facility may be denied management incentives for that period. Incentives previously made for an identified period of deficiencies will be treated as an overpayment and subject to recapture.

C. Inflation Factor

After combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. In setting an inflation factor, changes in industry wage rates and supply costs compared with CPI are observed and the lesser amount of change is expressed as a percentage and applied to the allowable reimbursable costs for the six-month rate setting period. The amount of change experienced during the six-month reporting period or the CPI becomes the inflation factor applied to the next six-month rate setting period. The inflation factor, once set for a given rate period, is not adjusted as it represents a reasonable expectation for cost increases.

Indicators used for tracing economic changes and trends include:

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1. Semi-Annual Cost Reporting - The average per patient day cost of service is compared to the cost incurred in providing the same services in the prior cost reporting period. The percentage of change is then expressed as an increase or decrease in the cost from the prior period.

2. Regulatory Costs - Regulatory costs, such as minimum wage increase, FICA increase, and Worker's Compensation changes may be considered as a component of the inflation factor.

3. National Data - The Consumer Price Index (CPI) for the most current cost reporting period is analyzed and compared with state experience.

D. Change in Bed Size

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if it affects the appraisal value of the facility. In this instance, an appraisal of the facility will be completed after the change in bed size has been certified. Any revision of the per diem rate as a result of the change in bed size will become effective with the month the facility changes were certified by the state survey agency.

E. Projected Rates

Projected rates will be established for new facilities with no previous operating experience for a period of eighteen months. The facility may choose to go off the projected rate at any time after a full six months of operating experience in a cost reporting period. Projected rates may be established for a maximum period of eighteen months where there has been a change of ownership and control of the operating entity, and the new owners have no management experience in the facility. Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by the State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control.

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Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting a projected rate.

At the end of the projected rate period, actual cost experience of the facility will be reconciled with the projected cost reimbursement and tested for reasonableness against the standards established for the bed range for the appropriate rate periods.

For facilities constructed after April 1, 1981 and financed by public bonded indebtedness, the actual cost experience of the facility will be based on the actual occupancy experience of the facility during the projected rate period, rather than the minimum occupancy standard. However, these actual costs will be compared with the same standards, as detailed above, and therefore subject to the same test of reasonableness.

Resulting overpayments from overprojection will be recovered by the State agency in accordance with provisions of Chapter 700, Long Term Care Regulations.

Rates based on projected costs do not include management incentives or occupancy allowance.

1. New Facilities

A projected rate for new facilities with no previous operating experience will be established as follows:

a. Standard Services - The cost standard established for the appropriate bed range peer group.

b. Mandated Services - The established CAP for the appropriate bed range peer group.

c. Nursing Services - The average of the costs established for the appropriate bed range peer group.

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d. Cost of Capital - The Standard Appraised Value (SAV) methodology applied to the facility. The facility will be appraised following certification for participation in the program.

2. Change of Ownership

A projected rate established for facilities where there has been a recognized change of ownership and control will be established as follows:

a. Standard Services - The cost standard established for the appropriate bed range peer group.

b. Mandated Services - The CAP of the costs established for the appropriate bed range peer group.

c. Nursing Services - The average of the cost established for the appropriate bed range peer group.

d. Cost of Capital - The Standard Appraised Value (SAV) established for the facility.

IV. Administrative Review

Procedures to be followed for administrative review and evidentiary hearings related to the per diem rate established for facility reimbursement are found in Chapter 700, Long Term Care Regulations.

V. Audits

Department audit staff will perform a desk audit of cost statements prior to rate setting, and will conduct on-site audits of facility records periodically.

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A. Desk Audit

Financial and statistical reports submitted by the participating facilities will be subjected to desk review and analysis for rate setting within 60 days of receipt. Incomplete and inaccurate cost reports are not accepted.

B. Field Audit

Periodic on-site audits of the financial and statistical record of each participating facility will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report, and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by Department staff for audit purposes upon notice. Records found to be incomplete or missing at the time of the scheduled on-site review, must be delivered to the Department within 15 days. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.

C. Record Retention

Audit reports will be maintained by the agency for five years following date of completion.

D. Credits and Adjustments

The State will account for and return the Federal portion of all overpayments to HCFA in accordance with the applicable Federal laws and regulations.

VI. OBRA '87 Requirements for Nursing Facilities

A. Computer Software - 1919(b)(2)(3)

As reflected in the Ernst & Young Analysis, pages 12 and 13, Attachment 1 to Supplement 1, a major portion of the OBRA cost impact is encompassed by the requirements for developing plans of care, updating plans of care, annual resident assessment and quarterly resident assessment.

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The industry estimate for the costs of implementing these OBRA requirements are based on a totally labor intensive approach, and primarily reflect increased staffing to meet these requirements. However, the agency has determined that these requirements can be met in a more technological manner while at the same time improving the quality of care planning and resultant care delivery, and at significant cost savings relative to the industry estimates.

The nursing facilities will be required to have a dedicated computer with an approved plan of care software package. The facility will be reimbursed for costs of the hardware and software through a one-time direct purchase not to exceed $12,000 substantiated by invoices from the supplier. The use of a computer in each facility is directed toward reducing manpower, improved care planning, and resulting increase in quality of care. The approved software package would both facilitate and improve care planning, would generate all required nursing and patient documentation, and facilitate development of Electronic Media Claims (EMC) transmissions for billing.

Updates to the software programs will be required as a part of the approval package. Approved software must guarantee ability for updates annually or more frequently, if required, to allow compliance with resident assessment instructions, evolving or changing regulatory requirements, changes in nursing service requirements, etc. It is recognized that a reasonable expectation for such software may require an annual users fee. This would be allowed in the administrative cost center.

B. Nursing Facility Costs for Transitional Period October 1, 1992 through September 30, 1993

1. Nursing Services - Staffing 1919(b)(4)

Based on the attached Supplement 1, an additional payment of $0.52 will be added to the per diem rates established for the rate periods October 1, 1992 through September 30, 1993 for the costs required to meet the increased RN staffing and the in-service nurse aide training requirements.

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The prospective payment rates established for these four rate periods will include projected wage increases for certified nurse aides.

2. Other OBRA Costs - 1919(b)(1)(2)(3)(4)(6)(7), 1919(c)(1)(2)(3)(4)(5)(6)(7)(8) and 1919(d)

Based on the attached Supplement 1, a per patient day additional payment of $0.82 will be made to the rates established for the periods 10-1-92 and 9-30-93, which is broken down as follows:

Quality Assurance Committee	.13
Updating Plan of Care	.18
Annual Resident Assessment	.25
Quarterly Resident Assessment	.15
Admission and Discharge	.07
Management of Resident Funds	.04

C. Final Implementation

Effective with nursing facility rates established for the rate period October 1, 1993, all costs necessary to meet Federal and State requirements for nursing facility services, excluding costs for NATCEP, will have been reported by the facilities on the semi-annual cost reports, therefore, the previous OBRA add-on is no longer necessary. Prospective rates will be established according to the methodology in the approved plan, ATTACHMENT 4.19-D-1, and will recognize all costs associated with the requirements in Section 1902 of the Act.

All allowable costs incurred by nursing facilities in providing care and services to Medicaid residents, whether or not they are resultant from the additional requirements of the Act, are subject to the test for reasonableness as required under the Boren amendment.

D OBRA '87 Amendment

Section 4[illegible] (A) of OBRA '87 amended section 1920(a)(13)(A) of the Act to require that States account for the cost of providing services required

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to attain or maintain the highest practical physical, mental, and psycho-social well-being of each resident eligible for benefits under title XIX. The State of West Virginia will not incur any additional costs related to the aforementioned sections of OBRA '90 since service required to attain or maintain the highest practical mental, physical and psycho-social well-being have been accounted for in our nursing assessment methodology originally implemented in 1981. Also, the State of West Virginia licensure requirements for nursing facilities provide that nursing facilities must include services that are required to attain or maintain the highest practical physical, mental, and psycho-social well-being for each resident. The licensure inspection of each facility documents that these requirements are met.

VII. Bed Reservation Policy

Reimbursement will be made to reserve a bed during a resident's temporary absence from the facility at the established per diem rate provided the facility is fully occupied and has a waiting list for admissions. A day of absence is defined as a twenty-four hour period.

Medical Leave of Absence

A bed may be reserved for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, and whose stay is more than twenty-four hours.

The maximum medical leave for a resident is twelve days in a calendar year.

Non-medical Leave of Absence

A bed may be reserved for a therapeutic leave which is included in the resident's plan of care.

The maximum non-medical leave for a resident is six days in a calendar year.